

PLEASE PRINT IN INK

LAFAYETTE BONE AND JOINT CLINIC, INC

PATIENT INFORMATION

ACCOUNT # _____

TO SEE: **(circle one)** Dr. Blanda Dr. Hodges Dr. Muldowny Dr. Stubbs Dr. Trahan

NAME OF PATIENT: _____
Last First Middle

ADDRESS: _____
Number and Street, Apt.# City State Zip

SOCIAL SECURITY#: _____ AGE: _____ DATE OF BIRTH: _____

SEX: ___M___F MARITAL STATUS: ___M___S DRIVERS LICENSE#: _____

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE: _____

HOME PHONE#: _____ CELL#: _____ OCCUPATION: _____

EMPLOYER: _____ EMAIL ADDRESS: _____

EMPLOYER ADDRESS: _____ WORK PHONE#: _____

SPOUSE'S NAME: _____

SOCIAL SECURITY#: _____ AGE: _____ DATE OF BIRTH: _____

SPOUSE'S EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ WORK PHONE#: _____

EMERGENCY CONTACT: _____ PHONE#: _____
(NOT LIVING WITH YOU)

NEAREST RELATIVE OR FRIEND: _____ PHONE#: _____
(NOT LIVING WITH YOU)

REFERRED TO OUR OFFICE BY: _____ PHONE#: _____

HAVE YOU EVER BEEN TREATED BY:
Dr. Cobb ___ Dr. Blanda ___ Dr. Muldowny ___ Dr. Hodges ___ Dr. Stubbs ___ Dr. Sledge ___ Dr. Trahan ___

IF YES, PLEASE EXPLAIN WHEN AND WHAT
FOR: _____

WHAT ARE YOU SEEING THE DOCTOR FOR?: _____

DESCRIBE INJURY: _____

DATE OF INJURY: _____

WAS THIS CAUSED BY AN AUTO ACCIDENT? ___YES___NO IS THIS A WORKERS' COMP INJURY? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

DO YOU HAVE MEDICARE? YES ___ NO ___ MEDICARE NUMBER _____

DO YOU HAVE BLUE CROSS? YES ___ NO ___ **IF YES COMPLETE INSURANCE INFORMATION ON NEXT PAGE**

IF WORKERS' COMP, IS IT A: LOUISIANA OR TEXAS CLAIM LONGSHORE & HARBOR JONES ACT
(Please Circle One)

DO YOU HAVE AN ATTORNEY FOR THIS INJURY? ___YES___NO

ATTORNEY'S NAME: _____ PHONE# _____

NAME OF PATIENT: _____

****IF THE PATIENT IS A MINOR OR STUDENT, PLEASE COMPLETE****

MOTHER'S NAME: _____

ADDRESS: _____ HOME PHONE#: _____

DATE OF BIRTH: _____ OCCUPATION: _____ SS _____

MOTHER'S EMPLOYER: _____ WORK PHONE#: _____

FATHER'S NAME: _____

ADDRESS: _____ HOME PHONE#: _____

DATE OF BIRTH: _____ OCCUPATION: _____ SS #: _____

FATHER'S EMPLOYER: _____ WORK PHONE#: _____

INSURANCE INFORMATION

(Please give receptionist all insurance cards as proof of coverage)

1. INSURANCE COMPANY NAME _____

ADDRESS _____

INSURED'S NAME _____ SOCIAL SECURITY # _____

POLICY # _____ GROUP # _____

2. INSURANCE COMPANY NAME _____

ADDRESS _____

INSURED'S NAME _____ SOCIAL SECURITY # _____

POLICY # _____ GROUP # _____

3. INSURANCE COMPANY NAME _____

ADDRESS _____

INSURED'S NAME _____ SOCIAL SECURITY # _____

POLICY # _____ GROUP # _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Lafayette Bone and Joint Clinic, Inc. or Dr. Blanda, Dr. Hodges, Dr. Stubbs, Dr. Muldowny, and Dr. Trahan to furnish any and all insurance company(s) or referring physicians all information they may request concerning my present illness or injury. I authorize the release of any medical or other information necessary to process my claim(s). I hereby assign to the provider all money to which I am entitled for medical and/or surgical expenses. Any credit balance will be refunded to the rightful party.

SIGNED: _____ DATE: _____

Patient or Parent

I authorize payment of medical benefits to the physician or supplier for services.

SIGNED: _____ DATE: _____

Patient or Parent

NAME OF PATIENT (Please Print Name): _____

ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. If you have health insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We request that office visits be paid at the time the service is rendered. To assist you, we accept cash, checks, MasterCard, or Visa. There will be a non-negotiable fee charged when a check is returned due to insufficient/uncollectible funds. A receipt for services rendered will be given to you that will have all information needed to file with your insurance company. Our office, accepting assignment of insurance benefits, will file surgery charges.

Accounts not paid in 90 days are subject to interest at the rate of 1.5% per month (18% annually). Returned checks may be subject to additional collection fees in addition to a \$35.00 returned check fee. If any account is placed in the hands of an attorney and/or collection agency for collection after default, the undersigned agrees to pay all cost of collection including a reasonable attorney's and/or collection agency fee.

Most companies generally consider our fees usual, customary and reasonable. This may not apply to companies who reimburse based on an arbitrary "schedule" of fees. As health care providers, our relationship is with you, not your insurance company or a third party such as an attorney or liability insurance. All charges are your responsibility from the date the services are rendered. If temporary financial problems arise, we encourage you to contact us promptly for assistance in the management of your account.

Our office has implemented a two (2) business day "Cancellation Policy". If you need to cancel or re-schedule your appointment, please notify us two (2) business days prior to your scheduled appointment. Lack of prior notification will result in a **\$15.00 cancellation fee**. Please be advised, our office will NOT be able to reschedule your appointment until the \$15.00 cancellation fee is paid in full.

I have read all the above information.

SIGNED: _____ DATE: _____

LAFAYETTE BONE AND JOINT CLINIC

(A PROFESSIONAL MEDICAL CORP.)
1103 KALISTE SALOOM RD, SUITE 100 & 102
LAFAYETTE, LA 70508

PHONE: (337) 234-5234

FAX: (337) 235-2121

ORTHOPAEDIC SURGERY

JOHN E. COBB, M.D. (1945-2011)
LOUIS C. BLANDA, JR., M.D.
DAVID S. MULDOWNY, M.D.
MALCOLM J. STUBBS, M.D.

PHYSICAL MEDICINE AND REHABILITATION

DANIEL L. HODGES, M.D.

NEUROLOGICAL SURGERY

JAYME TRAHAN, M.D.

AUTHORIZATION AND RELEASE

Insurers and managed care companies occasionally review medical charts to ensure compliance with company procedures. I understand that my chart may be selected for such review and that the confidentiality of the information in my chart will be preserved and I hereby consent to such review and release this physician and any such insurer or managed care company from liability for any reasonable review of my chart.

Signature of Patient or Parent (if minor)

Date

RELEASE OF MEDICAL RECORDS

I. TO: Drs. Cobb, Blanda, Hodges, Muldowny, Stubbs, and Trahan

I hereby authorize you to release to _____ any and
all information including the diagnosis and records of any treatment or examination rendered to me by any of the
above-named physicians.
(attorney)

Signature of Patient Date _____

Witness

II. Louisiana's Workers' Compensation law allows a healthcare provider to give the claimant's attorney a copy of all reports relating to the work injury without the claimant's authorization. (LA R.S. 23:1127) Unless you check below, we will send a copy of these reports to the last attorney you have identified. If you change attorneys you must notify us; until you notify us of the change, we will continue to send copies to your last attorney.

_____ No, do not send copies to my attorney _____
(Initials)

III. I, _____ hereby authorize John E. Cobb Marital Trust, Dr. Louis C. Blanda, Jr., Dr. Daniel L. Hodges, Dr. David S. Muldowny, Dr. Malcolm J. Stubbs, and/or Dr. Jayme Trahan to release copies of my medical records and/or x-rays to any referring physician and/or my spouse, daughter, son, or anyone else that I have listed below.

Name	Relationship
_____	_____
_____	_____
_____	_____

Signature of patient Date

DISCLOSURE OF FINANCIAL INTEREST

as Required by R.S. 37:1744 and
LAC 46:XLV.4211-4215

Louis Blanda Jr., M.D., Daniel Hodges, M.D., David Muldowny, M.D., Malcolm Stubbs, M.D., Jayme Trahan, M.D.

Date: _____

Patient Name: _____

Louisiana law requires Dr. Blanda Jr., Dr. Muldowny, Dr. Hodges, Dr. Stubbs and Dr. Trahan of Lafayette Bone and Joint Clinic, and other health care providers to make certain disclosures to a patient when they refer a patient to another health care provider or facility in which the physician has a significant financial interest. One of the physicians listed above may refer you, or the named patient for whom you are legal representative, to:

Facility/Business	Purpose	Provider with Financial Interest
Lafayette Surgical Specialty Hospital	Surgical/Hospital Services	Drs. Blanda Jr., Muldowny, Stubbs, & Trahan
Practical Healthcare Supply Inc	Surgical Instrumentation	Dr. Blanda Jr., Dr. Muldowny, Dr. Stubbs, Dr. Trahan
Ambulatory Surgery Center of Opelousas	Surgical/Hospital Services	Dr. Stubbs
Falcon Pharmacy LLC	Prescription Services	Dr. Blanda Jr., Dr. Muldowny, Dr. Stubbs, Dr. Hodges
Acadian Neurological Monitoring LLC	Neuromonitoring	Dr. Trahan
Neurosurgical Applications LLC	Surgical Instrumentation	Dr. Trahan
Camber Spine Technologies	Surgical Instrumentation	Dr. Trahan

There is a financial interest in the health care provider to whom you are being referred to, the nature and extent of which are as stated above.

If you prefer that any of these services be arranged with another provider, please discuss this with the clinic personnel at the time the services are being arranged.

PATIENT ACKNOWLEDGEMENT

I, the above-named patient, or legal representative of such patient, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

(Signature of Patient or Patient's Representative)

Print Name: _____

Date: _____